The Virginia Institute of Pastoral Care
2000 Bremo Road, Suite 105, Richmond, VA 23226
(804) 282-8332

Office Use Only
Chart No._____
Counselor No._____

PLEASE PRINT CLEARLY

Today's Date: _____/_____/_____

Last Name:_____ First Name:_____ Middle Name:_____

Street:_____ City: _____ State:_____ Zip:_____

Home Phone:_____Birth Date: _____/_____/_____ Social Security #:_____

Cell Phone: _____Work Phone:_____

Email: _____ Gender: M F Racial Heritage:_____

Marital Status S M Sep Div Wid Number of Dependents: ____Employer:_____

Occupation:_____ Gross Family Income Yearly: $_____

(THIS IS INCOME BEFORE TAXES. INCLUDE INCOME FROM INVESTMENTS, PENSIONS, ETC.)

Denomination/Faith:_____ Local Church/Parish/Synagogue/Mosque:_____

Emergency Contact:_____ Relationship _____ Phone:_____

Physician:_____ City/State _____ Phone: _____

Who referred you to VIPCare? _____ Relationship: _____

CLIENT IS RESPONSIBLE FOR PAYMENT.

Shall we file insurance claims on your behalf? ☐ **YES** ☐ **NO** If yes, please fill in the following:
(Also attach a copy of front and back of your insurance card.)

Name of Primary Insurance Carrier:_____ Date when coverage began:_____

Subscriber ID#: _____ Name of policy holder:_____ Policy holder Date of Birth:_____

Employer group:_____ Group number:_____

Client relationship to the policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other (_____)

I have reviewed the following information:

- ☐ **HIPPA Notice of the Privacy Practices of The Virginia Institute of Pastoral Care**
- ☐ **Informed Consent to Treatment**
- ☐ **Statement of Client's Rights**
- ☐ **Statement of Client's Responsibilities**

I accept these terms during our professional relationship.

_____ _____
Client / Guardian Signature Date

_____ _____
Counselor Signature Date

(PLEASE TURN OVER. YOU MAY REQUEST A COPY OF ANY FORM YOU WISH TO KEEP.)

OFFICE USE ONLY: Outside Billing_____
Circle if client is eligible for Minister Care benefits: UMC BAP EPIS LUTH BTSR UPSem Other_____
Sliding Scale Fee: $_____ ICD-10 Diagnosis Code: _____

HIPAA NOTICE OF PRIVACY PRACTICES OF THE VIRGINIA INSTITUTE OF PASTORAL CARE

A. We have a legal duty to protect health information about you.
B. We may use and disclose Protected Health Information (PHI) about you in the following circumstances.
    1. We may use and disclose your PHI to provide health care treatment to you.
    2. We may use and disclose your PHI to obtain payment for services.
    3. We may use and disclose your PHI for health care operations.
    4. We may use and disclose your PHI under other circumstances without your authorization.
    5. You can object to certain uses and disclosures of your PHI.
    6. We may contact you to provide appointment reminders.
    7. We may contact you with information about treatment, services, products or health care providers.
    8. We may not sell your PHI without your express written authorization.
    9. We may disclose the PHI of deceased clients to individuals involved in their treatment or payment for their treatment.
C. You have several rights regarding Protected Health Information about you.
    1. You have the right to request restrictions on uses and disclosures of your PHI.
    2. If you pay all costs of your treatment yourself you may restrict disclosure of your PHI to your health plan.
    3. You have the right to request different ways to communicate with you.
    4. You have the right to see and copy your PHI in the form you choose, provided your PHI is readily producible in that format.
    5. You have the right to request amendment of your PHI.
    6. You have the right to a listing of any disclosures of your PHI we have made.
    7. You have the right to copy this notice.
D. You may file a complaint about our privacy practices with our Privacy Officer.

INFORMED CONSENT FOR TREATMENT

I understand therapy offers no guarantees. By working with my therapist, I have the opportunity to get help with the problems and concerns I bring to therapy. I understand I will benefit in proportion to the effort I put into making changes and acting in new and different ways. I will develop these new choices in cooperation with my therapist. This effort will not be limited to the time in sessions but will include making the effort in between sessions. If I do not do these things outside the office, I understand the effectiveness of the therapy will be limited. I agree to collaborate with my therapist or to discuss with him or her the reasons why I cannot. I agree to ask any questions I have to clarify my therapeutic goals and to monitor progress towards them. I understand therapy will end when the goals of the therapy are met. I also understand I can terminate my therapy at any time. I agree to notify my therapist if I choose to end therapy before the goals are met. I also understand my therapist can end therapy if we do not make progress, or if our relationship working together does not produce results, or if I am no longer able to pay for therapy. If therapy is terminated early, my therapist will make a reasonable effort to refer me to another appropriate source of therapy or assistance.

STATEMENT OF CLIENT'S RIGHTS

Clients have the right to be treated with dignity and respect. Clients have the right to fair treatment regardless of race, religion, gender, ethnicity, age, disability, or source of payment. Clients have the right to have their treatment and other information kept private. Only in an emergency, or if required by law, can records be released without client permission. Clients have the right to information from staff and therapists, including an explanation of their condition and treatment, in a language they can understand. Clients have the right to know about all their treatment choices, regardless of cost or if they are covered by insurance or not. Clients have the right to get information about VIPCare's services and role in the treatment process. Clients have the right to therapist qualification information. Clients have the right to know the clinical guidelines used in providing and/or managing their care. Clients have the right to provide input on VIPCare's policies and services. Clients have the right to know about complaint, grievance and appeal procedures. Clients have the right to know about State and Federal laws that relate to their rights and responsibilities. Clients have the right to know of their rights and responsibilities in the treatment process. Clients have the right to participate in the formation of their plan of care.

STATEMENT OF CLIENT'S RESPONSIBILITIES

Clients have the responsibility to give therapists the information they need to deliver the best possible care. Clients have the responsibility to let their therapist know when the treatment no longer works for them. Clients have the responsibility to follow their medication plan. They must tell their therapist about medication changes, including medications given to them by other providers. Clients have the responsibility to treat those giving them care with dignity and respect. Clients should not take actions that could harm VIPCare employees, therapists or other clients. Clients have the responsibility to keep appointments. Clients should call their therapists as soon as possible if they need to cancel visits. Clients have the responsibility to ask their therapists questions about their care so they can understand their care and their role in that care. Clients have the responsibility to let their therapists know about problems with paying fees. Clients have the responsibility to follow the plans and instructions for their care. The care is to be agreed upon by the client and therapist.

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POLICIES AND PROCEDURES

CONFIDENTIALITY AND PRIVILEGED COMMUNICATION:

The standards of ACPE, the Virginia Board of Health Professions, and the insurance companies require your counselor to keep treatment records. Pursuant to Virginia law, client records are retained for six (6) years from the last date of service. **All information disclosed within sessions and the written records pertaining to these sessions are confidential and may not be revealed to anyone without your written permission, except where the law requires disclosure. To take action to protect endangered individuals from harm when, in the therapist's judgement, danger exists, the law may require disclosure in these circumstances: where there is reasonable suspicion of child or elder abuse or neglect, or where a client presents a danger to him/herself or to another person.**

The Virginia Institute of Pastoral Care, Inc.'s counselors are trained as pastoral & spiritual counselors whose primary role is to advise and provide spiritual counseling to help others discover for themselves solutions to their problems. It is the policy of the Virginia Institute of Pastoral Care, Inc. (VIPCare) that its **counselors do not testify in either criminal or civil trials and that it or its counselors do not produce or turn over any documents in the files relating to a client of VIPCare**. The Code of Virginia in Sections 19.2-271.3 and 8.01-400 provides that no minister is required to give testimony as a witness, and has been interpreted to mean that no minister may be compelled to turn over certain documents in a court or discovery proceeding. Many counselors on the staff at VIPCare are ministers and their status as ministers is central to the counseling services they provide. Information entrusted to the counselor is disclosed confidentially to enable the counselor to render spiritual counsel and advice with regard to such information in the usual discharge of their professional practice. The Institute encourages you to be free to discuss all issues in your life without the fear of your pastoral counselor discussing those issues in court proceedings or providing to anyone copies of any documents in a file relating to a client of VIPCare.

Acknowledgement: **I understand and accept the policies set forth above with respect to testimony by a counselor at VIPCare and disclosure of documents or any other information relating to me. I also understand and acknowledge that, in furtherance of these policies, I shall not request or attempt to compel my counselor to testify at any criminal or civil proceeding of any sort or to compel my counselor or VIPCare to produce any documents relating to the counseling services I have received for any reason.**

AVAILABILITY AND EMERGENCY PROCEDURES:

Clients may contact counselors between sessions by leaving a message on the counselor's confidential voice mail by calling 804-282-8332. **If you need to talk to someone right away and cannot wait for a return call, you can call the 24-hour mental health crisis services for your locality: Richmond: 809-4100; Henrico County: 727-8484; Hanover County: 356-4200; Chesterfield: 748-6356. If an emergency situation arises in which you are being harmed or are in danger of harming yourself or someone else, please call 911 or go the nearest emergency room.**

PAYMENTS, CANCELLATIONS, AND INSURANCE:

Your sliding scale fee is determined by your gross family income and number of persons in the family. The amount is established in conversation with your counselor in the first session. As a part of the process of assessing what treatment is appropriate, your counselor may use testing and/or consultation, charged at your sliding scale fee. Payment is due at each session, including the initial interview. Payments can be made by cash, check, debit card, MasterCard, Visa, Discover or American Express. There will be a fee for returned checks from the bank. A regular session is **50 minutes** at the VIPCare fee. **All scheduled appointments must be cancelled 24 hours in advance**, **or you will be charged $30.00 for the missed appointment or late cancellation.** Insurance companies do not reimburse for missed appointments. For sessions or services not covered by insurance, the client will pay a sliding scale fee of $_____.

If you wish to use **insurance** which covers outpatient mental health treatment at VIPCare, we are willing to file for those benefits. **It is your responsibility to know the specifics of your coverage, to preauthorize or verify authorization for services, and to provide complete and accurate insurance information. You are responsible for whatever portion of the payment insurance does not cover. We cannot guarantee that your insurance company will cover your counseling.**

The client has agreed to pay the following amount at each visit: _____.

If you default on your payment obligation, your account may be sent to a collection agency or collections attorney. If your account is sent to collections, you will be responsible for all costs incurred, including but not limited to collection fees, finance charges, court costs and attorney fees. Any lawsuit to collect sums you owe will be brought in the County of Henrico, Virginia.

I have reviewed the above information in this agreement. I have had the opportunity to ask questions and accept these terms during our professional relationship. Based on the terms of this agreement, I consent to participate in an evaluation and treatment with my counselor at The Virginia Institute of Pastoral Care. I understand that this agreement can be withdrawn at any time.

Client signature_____ Date_____

Counselor signature_____ Date_____

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Permissions Relating to Insurance

I authorize permission for The Virginia Institute of Pastoral Care, Inc. to contact my insurance company, _____(Name of insurance company), as necessary to pursue and/or inquire regarding professional counseling services. I authorize the release of any medical or other information necessary to process claims for insurance payment. I also authorize payment of benefits to the Virginia Institute of Pastoral Care as the supplier of services accepting assignment of benefits.

Client signature_____ Date_____

In order to coordinate services, your insurance company may ask whether The Virginia Institute of Pastoral Care has contacted **your primary care physician**. Do you wish to give permission for this contact?

☐ I hereby **give permission** to the Virginia Institute of Pastoral Care to contact my physician (name)_____, located at_____ _____, telephone_____ to inform my physician that I am being seen by (counselor's name)_____for treatment of _____ (main concern).

☐ I **do not give permission** to the Virginia Institute of Pastoral Care to contact my physician.

Client signature_____ Date_____

To be completed by your Counselor:

_____
_____
_____

Re: (Client Name)_____ (Date of Birth)_____

Dear Dr._____:

In an effort to coordinate care, I want to inform you that_____ is seeing me for treatment of _____.

The setting is outpatient ☐ Individual Counseling ☐ Group Counseling
☐ Family Counseling ☐ Other:_____

If you need any further information, please call me at (804) 282-8332.

Sincerely,

_____ _____
(Counselor Signature & Credentials) Date

For Office Use Only: Date sent to physician:_____ by:_____(initials)

[Office Use Only, Account #_____]

The Virginia Institute of Pastoral Care

CONFIDENTIAL PERSONAL HISTORY INVENTORY

(Complete or check all blanks that apply. Indicate areas you wish to discuss further.)

NAME: _____ **Age**:__ **Ethnic Heritage**:_____ **Today's Date**:_____

Education: Grade School 1 2 3 4 5 6 7 8 ; High School 9 10 11 12 ;

College 1 2 3 4 5 6+

Occupation: _____ Satisfied? _____ Get along with co-workers and employer?_____

Military history? No Yes (List branch of service & years.)

What individuals and groups are your **support system?**

CONCERNS & GOALS:

What **concerns** do you bring to counseling? Please list any **stressful contributing events** and when they occurred.

Check your **areas of concern**: Job School Family Marriage Social relationships
Physical Psychological Legal Financial Faith Other:_____

What do you hope to accomplish by coming to counseling? (your **goals**)

What do you **need** from your counselor?

HEALTH INFORMATION:

Rate your **physical health**: Excellent Good Average Poor Declining

Medical Conditions: None Asthma Chronic Pain Cancer Diabetes Pulmonary Disease Cardiovascular problems (Heart, Blood Pressure) Allergic to _____

Weight change recently? No Yes (Lost __lbs. Gained__lbs. Over what time period?_____)

How often and how do you **exercise**?_____

List important present or past **illnesses, and injuries** causing limitations:

What do you do to **relax**?_____

Date of **last medical examination:**_____**Allergies:**_____

List **current medications**, including dose, prescribing physician & purpose for each. (Attach page if needed.)

Check **symptoms** you are now experiencing: **Physical:** Pain in_____ Discomfort in_____

Mood: Sadness Hopelessness Low self-esteem Mood swings Irritable Numb Withdrawn

Anxiety: Worry Panic attacks Jitteriness High stress level Physical symptoms Excessive fear

Thought: Confusion Obsessions Easily distracted Poor concentration Less able to think Flashbacks Difficulty remembering Loneliness Helplessness Loss of pleasure Guilt

Behavior: Disorganized Aggressive Impulsive Reckless Compulsive acts Self-injury

Sleep problem: Early morning awakening Sleep too much Unable to sleep Awake tired

Eating problem Binge eating Obesity Low weight Obsession about food Self-induced vomiting

Concern about use of: Alcohol Tobacco Drugs Spending Gambling Internet Overwork Television Marijuana Cocaine Pornography Other (_____)

Thoughts of suicide Plan for suicide History of suicide in family

Threats or violence toward others **Fear of violence against you**

---PLEASE TURN OVER---

Alcohol and Substance Use:

Use:_____Frequency:_____History of Use:_____

What has been your **history of dealing with emotional difficulty**?

- ☐ Prior **counseling** If yes, when?_____ Helpful? ☐ What were the issues?_____
- ☐ **Self-help group**:_____
- ☐ Faced problems **alone**
- ☐ Helpful **family or social support system**
- ☐ History of **abuse or neglect** By whom?_____
- ☐ **Suicide attempt**(s) When?_____
- ☐ **Psychiatric hospitalization**(s) When?_____
- ☐ **Addictive use of** _____

RELIGIOUS BACKGROUND:

Faith preference:_____ **Childhood religious background**:_____

Do you **believe in God**? ◯ Yes ◯ No ◯ Uncertain Do you **pray**? ◯ No ◯ Yes (◯ Often ◯ Sometimes ◯ Rarely)

What **beliefs, values or practices** are important to you?

PERSONALITY INFORMATION:

List 3 of your most important **strengths**:

What is strength for you?_____Where can you get it?_____

List 2 **areas of needed growth**:

FAMILY OF ORIGIN:

Parents' marital status: ◯ Married ◯ Never married ◯ Divorced ◯ Remarried ◯ Widowed

If not raised by birth parent(s), **who raised you**? _____

Rate **childhood home**: ◯ Happy ◯ Average ◯ Unhappy ◯ Abusive (toward whom?_____)

___**Parents used alcohol** ___**Parents used drugs** (_Seldom _Sometimes _Often _Addicted)

Father: Occupation:_____ If living, age:____ If deceased, your age at his death:___

Describe him in 3 words:

Mother: Occupation:_____ If living, age:___ If deceased, your age at her death:___

Describe her in 3 words:

Your birth position in your family (e.g. 1st of 3 children): _____ of _____children

List **sisters' & brothers'** names, ages, sexes and marital status:

MARRIAGE OR RELATIONSHIP INFORMATION:

Status: ◯ Single ◯ Married ◯ Committed Relationship ◯ Dating ◯ Separated ◯ Divorced ◯ Widowed

First name of **spouse or significant other**:_____ Age:__ Occupation:_____

Satisfaction with relationship ◯ Very satisfied ◯ Satisfied ◯ Neutral ◯ Dissatisfied ◯ Very dissatisfied

Areas of concern in the relationship: ◯ Communication ◯ Conflict ◯ Money ◯ Children ◯ In-laws ◯ Sex ◯ Infidelity ◯ Jealousy ◯ Personal habits ◯ Alcohol/drug use ◯ Trust Other:_____

How would **your partner** describe the issue?

If married, in **what year**?_____ **Ages when married**: ___Self ___Spouse

How long did you know your spouse **before marriage**?_____

Have you ever **considered divorce**? ◯ No ◯ Yes If yes, what were your reasons?

List **previous marriage(s)** of self or spouse: (former spouse's first name; dates married; how ended)

CHILDREN: If you have children, list names, ages, sexes. Describe each with 3 words.

OPTIONAL QUESTION: If your life story had a title or a theme, what would it be?